Nova S
P.E. Health

PROVINCE OF NOVA SCOTIA

REPORT OF THE

Provincial Tuberculosis Hospitals

NOVA SCOTIA SANATORIUM

AND

POINT EDWARD HOSPITAL

FOR THE YEAR ENDED DECEMBER 31

1971

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To His Honour,

THE HONOURABLE VICTOR deB. OLAND

Lieutenant-Governor of Nova Scotia

Sir:

I beg to present herewith the report of the Provincial Tuberculosis Hospitals.

I have the Honour to be

Sir,

Your most obedient servant,

Hon. D. Scott MacNutt
Minister of Public Health

C. G. SIMMS, M.D., D.P.H.

Deputy Minister

Department of Public Health

Sir:

I have the honour to submit the Thirteenth Annual Report of Provincial Tuberculosis Hospitals. This is made up of the Sixty-seventh Annual Report of the Nova Scotia Sanatorium and the Twenty-third annual report of the Point Edward Hospital. These reports cover the calendar year, 1971. They are preceded by Table A, a combined statistical report.

Respectfully submitted,

H. B. Colford, M.D., D.P.H.

Acting Administrator

Tuberculosis Control Services

TABLE A

COMBINED STATISTICAL REPORT

FROM THE NOVA SCOTIA SANATORIUM AND POINT EDWARD HOSPITALS

CONCERNING THE PATIENT POPULATION, EXCLUDING TREATMENT OF SICK STAFF

FOR THE CALENDAR YEAR 1971

	Nova Scotia Sanatorium Est. 1904		Point Edward Hospital Est. 1949		Totals	
	1970	1971	1970	1971	1970	1971
Number of patients in hospital, Jan. 1/70	128	109	37	41	165	150
Total admissions during year	450	537	143	146	593	683
Total under care during year	578	646	180	187	758	833
Total discharges during year	469	546	139	153	608	699
Total patients in hospital Dec. 31/70	109	100	41	34	150	134
Total patient days	48,474	42,497	14,439	15,063	62,913	56,936

TABLE A (continued)

COMBINED STATISTICL REPORT

FROM THE NOVA SCOTIA SANATORIUM AND POINT EDWARD HOSPITALS

CONCERNING THE PATIENT POPULATION, EXCLUDING TREATMENT OF SICK STAFF

FOR THE FISCAL YEAR 1969-70 and 1971-72
(Apr. 1 to Mar. 31)

	Nova Scotia Sanatorium Est. 1904		Point Edward Hospital Est. 1949		Totals	
	1970-71	1969-70	1970-71	1969-70	1970-71	1969-70
Number of patients in hospital January 1	140	148	35	71	175	219
Total Admissions during year	498	451	155	138	653	589
Total under care during year	638	599	190	209	828	808
Total discharge during year	501	459	137	174	638	633
Total patients in hospital December 31	137	140	53	35	190	175
Total patient days	47,193	52,354	14,748	19,452	61,941	71,806

TOTAL COST TO THE PROVINCE INCLUDING
M.S.I. RECOVERIES FOR THESE TWO HOSPITALS

	N.S. Sanatorium	Point Edward Hospital	Totals
Total Cost 1969-70	1,996,314.58	788,757.91	2,785,072.49
Cost per patient day for year 1969-70	38.13	40.55	38.79
Total Cost 1970-71	2,305,315.01	822,842.36	3,128,157.37
Cost per patient day for year 1970-71	48.85	55.79	50.50

TABLE A (continued)

COMBINED STATISTICL REPORT

FROM THE NOVA SCOTIA SANATORIUM AND POINT EDWARD HOSPITALS

CONCERNING THE PATIENT POPULATION, EXCLUDING TREATMENT OF SICK STAFF

FOR THE FISCAL YEAR 1969-70 and 1971-72
(Apr. 1 to Mar. 31)

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Nova Scotia Sanatorium

Kentville, Nova Scotia

67th ANNUAL REPORT

Calendar Year 1971

SIXTY-SEVENTH ANNUAL REPORT

OF THE

NOVA SCOTIA SANATORIUM

FOR THE YEAR ENDING DECEMBER 31, 1971

GENERAL INFORMATION

Free treatment for tuberculous persons in Nova Scotia became effective July 1, 1946. Application for admission of a tuberculous or a suspected tuberculous patient to the Sanatorium is made by the family physician through the Director of the Health Unit of his district recommending further investigation and/or treatment of the patient. If approved, the Director then contacts the office of the Medical Director requesting the admission which is authorized without delay.

The Sanatorium may be reached daily by the Dominion Atlantic Railway. Taxis meet all trains at Kentville, from which it is only a short drive to the Sanatorium. There are good bus connections daily to and from Kentville.

An information pamphlet, "Welcome", is available from all Health Unit Directors and from the Sanatorium. Prospective patients should read this before coming forward for admission in order to be informed regarding clothing requirements, visiting hours for friends, and other pertinent matters.

NOVA SCOTIA SANATORIUM

Kentville, N. S.

1971

Honourable D. Scott McNutt

Minister of Public Health

-- ADMINISTRATIVE AND TECHNICAL STAFF --

MEDICAL - FULL TIME STAFF

Helen M. Holden, M.D., C.R.C.P.(C),F.C.C.P.	Medical Director
J. J. Quinlan, M.D., C.R.C.S.(C), F.C.C.P.	Thoracic Surgeon and Bronchoscopist
F. J. Misener, M.D., F.C.C.P.	Radiologist
A. Laretei, M.D.	Physician
Maria Rostocka, M.D.	Physician
*G. A. Kloss, M.D., F.C.C.P.	Physician
E. W. Crosson, M.D.	Physician

MEDICAL - CONSULTING STAFF

V. D. Schaffner, M.c., C.R.C.S.(C),F.A.C.S.	Surgeon
D. M. MacRae, M.D., C.R.C.S.(C),F.C.C.P.	Bronchoscopist
B. F. Miller, M.D., F.R.C.S.(Edin.) F.R.C.S.(C)	Consultant in Orthopedics
J. D. Archibald, M.D.	Consultant in Psychiatry
C. E. Jebson, M.D., C.R.C.S.(C)	Consultant in Urology
*D. H. Kirkpatrick, M.D.	Consultant in Anaesthesia
A. M. Sutherland, D.D.S.	Consultant Dentist

ADMINISTRATIVE AND TECHNICAL

P. S. Mosher, B. Comm.	Administrator
Miss E. Jean Dobson, R.N., B.Sc.N.	Director of Nursing
Mrs. K. Dakin, R.N.	Director of Nursing Service
Mrs. Catherine Boyle, R.N.	Director of Nursing Education
Miss Eileen Quinlan, B.Sc.,P.Dt.	Director of Dietary Services
Mrs. Virginia Atkinson, B.Sc.,P.Dt.	Asst.Dietitian (resigned June/71)
Mrs. Elizabeth Thompson, B.Sc.P.Dt.	Asst. Dietitian
Miss Helen Morse, R.T.	Senior Laboratory Technician
D. M. Brown, B.A., B.Ed., M.S.W.	Social Worker and Director of Rehabilitation

* Certified in specialty of Provincial Medical Board

Mrs. Elaine Murray, B.Sc.R.T.	Senior X-ray Technician
Adi S. Jagosh, R.T.	Chief Technician, Physical Medicine Dept.
Hector McKean, R.R.L.	Chief Medical Records Librarian

CHAPLAINS:

Rev. Dale MacTavish, B.D., Co-ordinating Protestant Chaplain
Rev. G. E. Saulnier Roman Catholic Chaplain
Rev. J. Douglas Archibald,D.D., United Church Chaplain
Rev. W. A. Trueman Anglican Chaplain
Prof.(Rev.) Charles Taylor, B.A., B.D., (Acadia) S.T.M.(Andover Newton) Chaplain - Supervisor, Clinical Pastoral Training, Nova Scotia Sanatorium
Associate Professor of Practical Theology, Acadia University

MEDICAL RECORDS COMMITTEE:
Dr. H. M. Holden, Chairman
Mr. A. H. McKean, Secretary
Dr. A. Laretei
Dr. M. Rostocka
Dr. G. A. Kloss
Miss E. J. Dobson, R.N.
Mr. P. S. Mosher

TISSUE COMMITTEE:
Dr. G. A. Kloss, Chairman
Dr. F. J. Misener, Vice Chairman
Dr. J. J. Quinlan

PHARMACY COMMITTEE:
Dr. M. Rostocka, Chairman
Mrs. Shirley Maxwell, C.D.C.,Secretary
Dr. H. M. Holden
Dr. E. W. Crosson
Miss E. J. Dobson, R.N.
Mr. P. S. Mosher

HOSPITAL INFECTIONS COMMITTEE:
Dr. J. J. Quinlan, Chairman
Miss V. Skerry, R.N., Secretary
Dr. G. A. Kloss
Miss E. MacQuarrie, R.N.
Miss Helen Morse
Mrs. J. Ells
Charles Sheffield
Miss E. J. Dobson, R.N.
Mr. P. S. Mosher

FIRE PROTECTION COMMITTEE:
Mr. P. S. Mosher, Chairman
Dr. H. M. Holden
Miss E. Jean Dobson, R.N.
Mr. B. Robinson
Miss Eileen Quinlan
Mrs. J. Ells

The Nova Scotia Sanatorium was founded in 1904 and was the first provincially owned and operated Sanatorium in Canada. During the early years of its existence when the "cure" consisted of bed rest, diet, and fresh air, the institution grew rapidly and by the end of the first World War had reached a peak population of 400. During this period, many of the familiar brown wooden buildings in use today were built. The Sanatorium continued to operate at high levels of occupancy until the 1930's when the first definitive treatment, surgery, was introduced. At the same time, the newest of the patient care facilities was constructed. 1947 saw the first use of a drug effective against tuberculosis and from then on a dramatic decrease in the incidence of the disease has been measured by the closure of tuberculosis units in other places and a substantial decline in the utilization of the Sanatorium.

The rate of decrease in patient days has accelerated from the year previous to 12.3% (Table I). The actual decrease in tuberculosis patients was 19% which was partially offset by a 27.4% increase in nontuberculous patient days. Nontuberculous patient days now account for 21% of the total patient day volume of the Sanatorium. It is becoming increasingly evident that the institution is fulfilling a very useful role in the treatment of other respiratory diseases.

Discharges (Table II) increased by 77 to 546. While the numbers of patients with active tuberculosis and staff members admitted declined quite substantially, they were more than offset by an increase in patients with inactive tuberculosis and other respiratory diseases. Eighty-seven more nontuberculous patients were investigated during 1971 than in 1970.

The length of stay for tuberculosis patients decreased quite significantly during the year by 13% to an average of 287 days. This decrease is the result of a deliberate and concerted effort on the part of staff to return patients to their homes as early as possible during the treatment phase. Because of the relatively small number of patients included in the calculation from Table V, the length of stay can vary quite significantly from year to year. The ranges in the diagnostic groups of minimal, moderately advanced, and far advanced are indicative of this and in any year when one of the long stay patients is discharged the length of stay could show a substantial increase. However, the trend is toward shorter lengths of stay and it appears that this is being maintained in all but the most difficult cases.

The nontuberculous length of stay decreased from 37 days to 32 days in 1971. Table III (C), listing the diagnoses of nontuberculous patients, gives a rather varied list of diseases and many require a relatively long period of hospitalization for investigation and treatment. There is little doubt that the Nova Scotia Sanatorium is growing in prominence as a treatment facility for nontuberculous respiratory disease and fulfilling both a regional and provincial need. The greatest impact of this service is regional as borne out by Table VI. Seventy-three per cent of all nontuberculous patients admitted had residence in the counties of Hants, Kings, Annapolis and Digby, with the remainder coming from other areas of the province. The range of diagnoses is outlined in Table III (C) which shows the broad range of medical and surgical admissions. The most dramatic are traumatic injuries to the chest and the Nova Scotia Sanatorium has been able to render acute care when it was otherwise unobtainable within the area. The main resources used in this regard are the expertly trained medical staff and other supporting personnel and the life sustaining equipment available for the treatment of chest diseases.

Age grouping of patients does not show any significant variance from the previous year. The bulk of the patients treated at the Sanatorium are in the over 50 years age group which requires that special emphasis be placed on the needs of elderly people. In this regard, an active chaplaincy service is provided along with social and recreational activities. During the year, steps have been taken to change the role of the Rehabilitation Department from occupational retraining to that of providing diversional activity. Also, at the end of the year, plans were made to have a Patients' Committee organized. Representatives of the staff met with a group of patients to outline the possibilities of such a program in terms of providing social activities for the patient body as a whole, and as well, to give the patients an opportunity to communicate with the Administration of the hospital on some effective basis. By year end, the patients themselves had organized a representative committee and were preparing to put together a program.

The volume of the surgical service did not change significantly from the year previous as indicated by Table VII. The number of major procedures decreased slightly from 73 in 1970 to 67 in the present year. Minor procedures decreased to 131 as compared to 135 in 1970. In addition to the surgical procedures listed in Table VII, the thoracic surgery service was also called upon a number of times to provide services at the Blanchard-Fraser Memorial Hospital. We have not kept a record of this service and therefore the Sanatorium contribution to local and regional health services cannot be clearly identified, but it is considered to be meaningful.

The X-ray Department had a 27% increase in the work load over the previous year. The total of procedures was 8,171 and the increase can be attributed entirely to films interpreted for Health Units, particularly the Atlantic Health Unit which increased by 1,522.

The work load of the service laboratory at the Nova Scotia Sanatorium increased by 13% in 1971 over the previous year. The increase was fairly evenly divided between the general laboratory and the milk and water laboratory. The increase in general laboratory work load is indicative of the greater emphasis on acute care as more nontuberculous patients are admitted. It is certain that this trend will continue as more beds are freed by a decline in tuberculosis admissions. The milk and water laboratory services the Fundy Health Unit and the increase is attributed entirely to additional services requested by them.

The functions designated as Special Services in Table X did not demonstrate a significant change from the previous year with the exception of inhalation therapy. 1971 was the first full year in which a trained inhalation therapist was on staff and as a result the demand for services could be partially filled by this person. The increase during the year 1971 was 21% and it is felt that percentage increases of this magnitude will be evident in succeeding years as the demand for both in-patient and out-patient inhalation therapy services will increase in response to the need for more respiratory care. Coupled with the increase in inhalation therapy services is the increase in the demand for blood gas analysis and pulmonary function tests. This is a critical part of a respiratory service and the expansion in demand for these two services will closely parallel that in inhalation therapy.

During 1971, it became possible to close one nursing unit and at year's end, six actively operating units were open. The nursing department and administration are concerned about the number of units since the rate of utilization of each is somewhat below an optimum level. The net result is often ineffective allocation of nursing personnel.

The whole matter is currently under review and it is anticipated that it will be possible to combine more of the units and decrease the number in operation.

The nursing education department continued its role in providing training to student nursing assistants, During the year, discussions were held with the Board of Registration of Nursing Assistants to determine ways in which the clinical experience for the students could be expanded. As a result, affiliation arrangements were concluded with the Blanchard-Fraser Memorial Hospital and the Kings County Hospital for rotation in medical-surgical nursing, obstetrics, pediatrics, urology, and psychiatry. At the same time, it was realized that the viability of Vocational School programs for nursing assistants was being clearly established and, within the next two years, the Sanatorium program would likely give way to this concept when a school is established in the region. 1971 saw the final affiliation of student nurses from diploma schools at the Nova cotia Sanatorium. This was brought about by the shortening of the basic nursing training course to two years.

The general service departments of the hospital -- dietary, laundry, housekeeping, maintenance and plant operation -- provided their usual high standard of service. In the latter part of the year, negotiations were carried out with the Eastern Kings Memorial Hospital in Wolfville for the provision to them of consulting dietitians' service. Agreement was successfully concluded and the service was begun in January, 1972.

A number of changes to the physical plant were made during the year. In January, by a re-organization of the dietary department, it became possible to close the diet kitchen serving the West Infirmary and this function transferred to the diet kitchen in the East Infirmary. The

result was better utilization of staff and economy in operation. Also, during the year it was possible to demolish Pavilions 5, 6 and 7 and the Rehabilitation workshop. The structures had been built immediately following World War I and through the years have become completely outmoded and hazardous. To accommodate this change, the newer but vacant nurses' residence building was renovated to provide office space for the Sanatorium and the Departments of Public Health, Education, Lands and Forests, and the Victorian Order of Nurses. At the same time, plans were under way to rationalize the use of other space in terms of present day needs and future projections to determine if the whole complex could be made much more compact, thus increasing its efficiency and effectiveness.

In June of 1971, the first large scale fire and disaster drill was held at the Sanatorium. We were extremely fortunate in this exercise to have the co-operation of the Sanatorium Volunteer Fire Department, the Kentville Volunteer Fire Department and all other fire departments in Kings County tied together by the Mutual Aid network. The drill involved evacuation and an attempted rescue from the third floor of the West Infirmary building. Approximately 150 firemen with 18 pieces of equipment responded to the call and held a very worthwhile drill lasting for approximately three hours. Many lessons were learned as a result of this drill but perhaps the most important was the serious risk to life and limb of patients housed on the third floor of the building in question. Immediately after the drill, this floor was evacuated and closed down as a nursing unit. We wish to express sincere appreciation to the fire departments involved on this occasion and as well to the Sanatorium Fire Department and the Kentville Fire Department for their continued interest and assistance throughout the year in the maintenance of a high standard of fire prevention and safety.

Costs for the Nova Scotia Sanatorium are reported in the Public Accounts and will not be repeated here. The period most closely covering the calendar year 1971 is the period ending March 31, 1972. We are very gratified to note that measures aimed at cost control and increased productivity were reflected in the financial performance. The actual expenditure for the fiscal year, 1971-72, was 2.6% under the total expenditure of the year previous and the expenditures during the most recent fiscal year were 12.8% under the approved estimates. However, the rate of decline in patient days was greater than the decline in costs which increased the patient day rate quite substantially. This is quite disconcerting since the actual improvement in performance cannot be measured against the traditional yardstick of cost per patient day. It is simply not possible to make a sufficient number of short run changes in operation to keep the two in balance. Nevertheless, we are pleased to have been able to contain costs and at least prevent an increase in the total dollars expended.

The following people were honoured on their retirement during the year for the years of faithful service given to the Sanatorium.

Myrtle Harvey, waitress, 12 years' service
Mary Doucette, PBX operator, 13 years' service
Percy Doucette, CNA, 19 years' service
Grace Adams, clerk-typist, 20 years' service
Beatrice DeAdder, laundress, 20 years' service
Nora Cheesman, nursing supervisor, 12 years' service
Laurie Banks, kitchen orderly, 20 years' service
Marion Lacey, teacher, 15 years' service
Stephen Mullen, postal clerk, 14 years' service

The Sanatorium appreciates the interest and support of the people from the town of Kentville and surrounding area for their continued moral support to patients. Assistance given by individual citizens, service clubs, church, social, and fraternal groups has done much to promote the aims and objectives of the Nova Scotia Sanatorium and to provide comfort for patients.

In closing, we would like to acknowledge our sincere appreciation to Dr. J. S. Robertson, Deputy Minister of Public Health, and Dr. H. B. Colford, Acting Administrator, Tuberculosis Control Services, for the support that they have given us during the year. Their complete co-operation and also the co-operation of other government departments and health units make the task of operating this institution most rewarding.

P. S. Mosher,
Administrator

STATISTICAL REPORT

FOR THE CALENDAR YEAR ENDING DECEMBER 31, 1971

Table I

	1971	1970	1969
Number of patients in residence at first of year	109	128	133
Number of patients admitted during the year	330	283	319
Number of patients readmitted during the year	207	167	163
Total number of patients treated during the year	646	578	615
Number of patients discharged during the year	546	469	487
Number of patients in residence at end of year	100	109	128
Number of patient days treatment	42,497	48,474	52,887

		1971	1970
Number of days treatment	- tuberculous	33,282 or 78%	41,072 or 85%
	- nontuberculous	9,085 or 21%	7,132 or 15%
	- staff	130 or 0.3%	270 or 0.6%

Table II PATIENTS DISCHARGED CALENDAR YEAR 1971

		1971	1970
TUBERCULOSIS:			
Active:		114	129
First Treatment experience	81		
Retreatment	10		
To continue treatment	23		
Inactive:		105	78
Investigation of activity	69		
Treatment of nontuberculous disease	36		
Tuberculin Converter		3	
Total patients with tuberculosis		222	207
INVESTIGATION - PROVEN NONTUBERCULOUS:		280	193
New	206		
Previously treated at Sanatorium	74		
STAFF:		44	69
TOTAL DISCHARGES		546	469

Table III(a)

PRINCIPAL DIAGNOSIS OF PATIENTS DISCHARGED AFTER TREATMENT FOR ACTIVE TUBERCULOSIS

Calendar Year 1971

	First Treatments	Retreatment and transfers
Primary infection - active	4	1
Reinfection pulmonary tuberculosis:		
Minimal	23	5
Moderately advanced	29	11
Far advanced	16	10
Miliary	1	
Silicotuberculosis	1	
Pleural tuberculosis	3	2
Bursitis	1	
Meningitis	1	
Osteomyelitis	1	
Spondylitis	1	4
TOTAL	81	33

Table III (b)

PRINCIPAL DIAGNOSIS OF PATIENTS DISCHARGED WHO HAD INACTIVE TUBERCULOSIS ON ADMISSION

Aspergillosis	1
Primary malignant neoplasm of lung	1
Osteochrondoma of rib	1
Acute bronchitis	2
Influenza	1
Pneumonia	8
Emphysema	1
Chronic Obstructive Pulmonary Disease	13
Abscess of Lung	2
Broncholithiasis	1
Hydrocele	1
Haemoptysis, undetermined etiology	1
Acute respiratory failure	3
TOTAL	36

Table III (c)

DIAGNOSES OF NONTUBERCULOUS PATIENTS DISCHARGED

Calendar Year 1971

(Staff and those previously treated for same disease excluded)

Sarcoidosis	5
Bird Fancier's lung	1
Carcinoma of esophagus	1
Carcinoma of larynx	1
Primary malignant neoplasm of lung and bronchus	22
Secondary malignant neoplasm of thoracic organs	4
Benign neoplasm of bone	2
Lipoma, mediastinum	1
Infarction, pulmonary	1
Bronchopneumonia	12
Pneumonia, unspecified	14
Chronic bronchitis	15
Emphysema	3
Bronchial asthma	7
Other Chronic Obstructive Pulmonary Disease	47
Empyema	2
Pleurisy with effusion, nontuberculous	4
Spontaneous pneumothorax	7
Abscess of lung	3
Pneumonoconiosis	1
Farmer's Lung	4
Fibrosis of lung, etiology undetermined	5
Bronchiectasis	7
Atelectasis, postoperative	1
Leoffler's syndrome	3
Broncholithiasis	2
Diaphragmatic hernia	4
Haemoptysis, etiology undetermined	9
Gunshot wound to chest	1
Other sundry diagnoses	11
No significant disease or not diagnosed	6
TOTAL	206

Table IV

ACE GROUP OF PATIENTS DISCHARGED

CALENDAR YEAR 1971

AGE GROUP	TUBERCULOUS			NONTUBERCULOUS		
	Male	Female	Both Sexes	Male	Female	Both Sexes
0 - 4		4	4			
5 - 9		1	1			
10 - 14	1	2	3	1	1	2
15 - 19	9	4	13	2		2
20 - 29	8	13	21	8	12	20
30 - 39	9	3	12	8	14	22
40 - 49	24	10	34	23	17	40
50 - 59	39	14	53	49	20	69
60 - 69	31	8	39	63	14	77
70 - 79	21	11	32	25	13	38
80 +	5	5	10	9	1	10
ALL AGES	147	75	222	188	92	280

Table V

LENGTH OF IN-HOSPITAL TREATMENT PERIOD

First Treatment Experience - Discharged on Medical Advice

Calendar Year 1969

Diagnostic Group	Number of Cases	Total Days	Range	Average Days
Minimal	16	3434	62 - 459	215
Mod. advanced	17	4484	66 - 442	264
Far advanced	15	7132	325 - 935	475
Miliary	3	1089	270 - 493	363
ALL CASES	51	16,139	62 - 935	316

Calendar Year 1970

Diagnostic Group	Number of Cases	Total Days	Range	Average Days
Minimal	6	1406	21 - 397	234
Mod. advanced	25	6907	90 - 419	276
Far advanced	19	8272	234 - 713	435
ALL CASES	50	16,585	21 - 713	331

Calendar Year 1971

Diagnostic Group	Number of Cases	Total Days	Range	Average Days
Minimal	19	3703	18 - 396	195
Mod. Advanced	24	6255	70 - 585	261
Far advanced	10	4932	117 - 844	493
Miliary	1	589	589	589
ALL CASES	54	15,479	18 - 844	287

Table VI

COUNTY OF RESIDENCE OF PATIENTS DISCHARGED

Calendar Year 1971

COUNTY OF RESIDENCE	Nontuberculous	Tuberculous	Total
Annapolis	40	14	54
Antigonish	3	10	13
Cape Breton	4	5	9
Colchester	6	15	21
Cumberland	3	16	19
Digby	10	8	18
Guysborough	6	6	12
Halifax	9	58	67
Hants	25	10	35
Inverness	0	8	8
Kings	128	24	152
Lunenburg	17	22	39
Pictou	21	13	34
Queens	1	1	2
Richmond	1	2	3
Shelburne	0	2	2
Victoria	1	0	1
Yarmouth	5	7	12
Non Resident	0	1	1
TOTAL	280	222	502

Table VII SURGICAL PROCEDURES
Calendar Year 1971

A.	Pulmonary Resection	49
	Indication: (including biopsy for diagnostic purposes)	
	Abscess, chronic	1
	Bronchiectasis	5
	Bronchogenic Cyst	1
	Carcinoma, primary	9
	Carcinoma, secondary	2
	Cyst, Giant	2
	Farmers' Lung	1
	Hamman Rich Syndrome	1
	Pneumonitis, chronic	2
	Silicosis	1
	Spontaneous Pneumothorax	3
	Tuberculosis	21
	For Pulmonary Tuberculosis: Type of operation	
	Lobectomy	5
	Bisegmentectomy	3
	Segmentectomy and Wedge Resection	2
	Segmentectomy	7
	Wedge Resection	4
		21
	Operative Mortality	0.0%*
B.	Sundry Surgical Procedures - Major	24
C.	Sundry Surgical Procedures - Minor	198
	Total Surgical Procedures	243

* Based on tuberculosis cases only

Table VII (Cont'd)

D. Anaesthesia:

Pentothal sodium + Nitrous Oxide + Halothane + Syncurine + Anectine	63
Pentothal sodium + nitrous oxide + halothane	5
Pentothal sodium + anectine	5
Pentothal sodium + nitrous oxide	1
Nitrous oxide + Halothane	4
Halothane	1
Novocaine 2%	213
Pontocaine 2%	377
Xylocaine jelly	4
Spinal	5

Table VIII X-RAY DEPARTMENT REPORT

Abdominal, flat film		26
Barium enema		7
Bones & Joints		281
Bronchograms		89
Chest		4779
Cystogram		3
Dental		23
Fistula - contrast media		4
Gastrointestinal		16
Kidney Ureter-Bladder		22
Oesophagus		9
Outside films interpreted		2827
For Atlantic Health Unit	1799	
Others	1028	
Planigrams		77
Sinus & mastoid		8
		8171

2870 Outpatient X-ray examinations included in above table.

Film developing service for Department of Public Health:

Cobequid Health Unit	3274
Fundy Health Unit	1346
Lunenburg-Queens Health Unit	765
Northumberland Health Unit	1793
All Units	7178

Table IX LABORATORY REPORT

Units of work performed:	1971	1970	1969
General laboratory	106,518	98,400	97,798
Milk and Water Laboratory	17,649	11,587	12,618
Total Units performed in Nova Scotia Sanatorium Laboratory	124,167	109,987	110,416
Units of work performed for the Sanatorium by Public Health, Red Cross, and Biochemical Laboratories, Halifax	19,380	21,589	16,989
Units of work performed for the Sanatorium by:			
Pathology Laboratory, Halifax	1,344	1,152	1,264
Blanchard Fraser Memorial Hospital, Kentville	356	166	71
Total Units of Work referred out	21,680	22,907	18,324

Table X SPECIAL SERVICES

		1971	1970
A. Outpatient Department:			
Total visits to chest clinic		3101	3020
Ex-patients	899		
Staff	905		
Others	1297		
BCG Clinic:			
Total vaccinations		45	60
Nurses - graduate	1		
- students	36		
Other hospital personnel	1		
Others	7		
B. Bronchoscopy Service:			
Bronchoscopic examinations		289	223
C. Physical Medicine Service:			
1. Physiotherapy:			
Electric muscle stimulation		198	198
Exercise - active and passive		4602	4345
Massage		140	160
Infra Red Light therapy		2487	2346
Short Wave therapy		565	287
Steam packs		876	602
Wax baths		454	614
Ultra sonic muscle stimulation		141	98

Table X (cont'd.)

	1971	1970
2. Inhalation therapy:		
Intermittent Positive Pressure Breathing	11,549	9516
Postural Drainage*	542	1312
Postural Drainage to obtain cytology specimen	62	263

* Postural Drainage includes 458 with IPPB to facilitate the procedure

D. Miscellaneous Diagnostic Procedures:

Department of Physical Medicine:		
Audiograms	97	142
Electrocardiograms	436	335
Cardiorespiratory Laboratory:		
Blood Gas analysis	542	334
Pulmonary Function tests	574	251
Bronchospirometry	0	1

E. Psychiatric Services:	Patients	Visits
Brain Disorders	6	6
Mental Deficiency	2	4
Psychiatric Disorders	12	26
Psychoneurotic Disorders	17	28
Personality Disorders	16	24
Alcoholism	2	3
Situational Adjustment Reaction	1	1
	56	92

F. Dental Service:		
Examinations	179	181
Prophylactic treatments	49	55
Extractions	193	218
Fillings	73	143
Artificial dentures (professional services only)	36	23

G. Special Services		
Allergy tests	27	36
Autopsy examinations (autopsy rate 38%)	11	11
Cystoscopy	6	9
Dressings	56	123
Electrocardiograms interpreted for Point Edward Hospital	40	53
Electroconvulsive therapy	5	
Eye examinations	208	124
Esophagoscopy	1	2
Injection of joint	1	8
Lumbar puncture	16	8
Pelvic examinations	94	71
Piercing of ears	2	18
Sternal Puncture	11	7
Syringing of ears	36	50

TWENTY-THIRD ANNUAL REPORT

OF

POINT EDWARD HOSPITAL

N. S. DEPARTMENT OF PUBLIC HEALTH

SYDNEY, NOVA SCOTIA

For the calendar year

Ending December 31, 1971

Doctor H.B. Colford
Acting Administrator of Tuberculosis Control Services

MEDICAL STAFF

Medical Superintendent	D. D.S. Robb
Asst. Medical Superintendent	Dr. T.K. Krzyski
Consultants	Dr. D.B. Archibald -- Urology
	Dr. W. MacIsaac -- Bronchoscopy (retired Sept 1971)
	Dr. R.G. Chokshi -- Bronchoscopy (since October 1971)
	Dr. E.C. McDonagh -- Psychiatry
Courtesy Consultants	Dr. H.R. Corbett -- Radiology
	Dr. R. Mathieson -- Pathology
	Dr. H.M. Holden -- Cardiology

NURSING STAFF

Director of Nursing	Miss Katherine MacKenzie, R.N.
Asst. Director of Nursing	Mrs. Flora MacDonald, R.N.
O.R. Supervisor	Miss Helen Chiasson, R.N.
Night Supervisor	Mrs. Edna MacDougall, R.N.
Evening Supervisor	Mrs. Lenore Lawley, R.N.
Relief Supervisor	Mrs. Winnifred Protheroe, R.N. (Oct 1/72)
Head Nurses	Mrs. Irene Pierrynowski, R.N.
	Miss Theresa Bisson, R.N.

ADMINISTRATIVE AND TECHNICAL STAFF

Administrator & Medical Supt.	Dr. D.S. Robb
Chief Clerk	Mrs. M. Josephine MacKinnon
Stores Supervisor	Mrs. Isobel MacPherson
Medical Records	Miss Vivian Fraser
Dietitian	Miss B. Joyce Lewis (to Dec 31/72)
Housekeeper	Mrs. Maude Sutton (retired Aug 31/71)
	Mrs. Mary Young (since Sept 1/71)
Laboratory	Miss Margaret Lamond
X-ray	Mrs. Ada O'Callaghan
Maintenance	Mr. Hubert Lewis
Rehabilitation	Mrs. Elizabeth Reid

POINT EDWARD HOSPITAL

ANNUAL REPORT - 1971

"The old order changeth, yielding place to new,
And God fulfills Himself in many ways
Lest one good order should corrupt the world."

In the closing days of 1972 and the beginning of a new year, we are very much aware that history is pressing in upon us, for on December 15th the announcement was made that, because of reports from the Dominion Fire Commissioner and the Provincial Fire Marshall declaring the fire hazard in the hospital building to be unacceptable, the hospital would be closed as soon as practical and patients would be moved to other facilities in the Sydney area, as soon as such could be found.

A SENSE OF HISTORY: The fact that such a decision could be made reflects the very great improvement which has occurred in the Public Health picture in recent years, and for such improvement the public should be grateful, even while admitting that the rupturing of old associations will be painful to some. In 1903, four years after the opening of the Nova Scotia Sanatorium in Kentville, and the first year for which we have accurate figures, over 1100 lives were claimed by tuberculosis in Nova Scotia, giving a death rate of 208 per 100,000 population. In 1946, the year in which "free treatment for tuberculosis" was introduced to the province, the death rate was still high, at 62.6 per 100,000. At that time sanatorium treatment consisted of bed rest, fresh air, and various methods of "collapse therapy", notably pneumothorax and thoracoplasty, to give greater rest to the diseased portion of the lung. The following year saw the dawn of a new era -- Streptomycin was introduced, the first antibiotic to inhibit the growth of the tubercle bacilli, making it possible to treat successfully forms of the disease which had hitherto been invariably fatal.

Point Edward Hospital was opened on January 14, 1949, and its 187 beds brought to 1246 the total number of Tuberculosis Treatment beds in operation in the province during the early 1950's, but even with this treatment capacity there were long "waiting lists" of patients requiring

admission as soon as a bed became available. However, the tide was turning, and a few years later the smaller Tb Units were being closed -- The Lourdes Sanatorium in Pictou County, the Sydney City Hospital Tb Annex, the St. Joseph Hospital Tb Annex in Glace Bay, and the Highland View Tb Annex in Amherst had all been closed by the end of 1956, followed by the closing in 1957 of St. Martha Hospital Tb Annex in Antigonish, the Glace Bay General Hospital Tb Annex, the Halifax Tuberculosis Hospital, and the Tuberculosis Service of Camp Hill Hospital. The provincially operated Roseway Hospital in Shelburne ceased operation as a Tb Hospital late in 1960, and in the decade following the N.B. Sanatorium gradually reduced its number of treatment beds from 400 to 200, and this figure is currently being further reduced to about 120 beds.

The past ten years have seen a gradual reduction in the number of patients in Point Edward Hospital, from its peak days in 195[illegible] when there were extra beds in the library and corridors and every nook and cranny was filled, until it became possible to close first one ward, then another, to the mid-December '72 date when, with only 3[illegible] patients in hospital and a number of these about to be discharged, the decision was made to move to smaller and more fire-proof facilities. A recapitulation of some statistics from past annual reports may help place today's situation in perspective:

YEAR		ADMISSIONS	PATIENT DAYS	YEAR-END CENSUS	AVERAGE CENSUS
1949	(8½ mos. Jan 1, | - Nov 30/49)	252	33,850	138	105
1950	(16 mos, Dec [illegible] | - Mar 31, [illegible])	213	68,003	145	140
1951	([illegible] mos, Apr 1/51 | - Mar 31/52)	213	45,562	153	124
1952	(12 mos, fiscal year		254	55,560	140	152
1953		"	241	47,610	140	130
1954		"	331	57,365	157	157
1955		"	284	49,725	145	136
1956		"	291	52,210	140	143
1957		"	321	56,582	154	155
1958	(9 mos, | calendar year)	220	54,480	145	149
1959		"	293	53,092	136	145
1960		"	260	50,830	130	139
1961		"	243	41,139	133	113
1962		"	437	42,125	110	115
1963		"	198	34,473	76	94
1964		"	191	28,910	83	79
1965		"	217	31,435	74	86
1966		"	183	29,146	70	80
1967		"	173	25,129	52	69
1968		"	193	23,715	64	59
1969		"	165	22,382	37	61
1970		"	143	14,439	42	40
1971		"	146	15,063	34	41
1972		"	128	13,194	24	36

It can be seen that the number of yearly admissions has dropped to half and that the average census has dropped to less than a quarter of its figure in the 1950's. This reduction in admissions is a reflection of the decreasing incidence of tuberculosis, that fewer individuals are contracting the disease and that fewer old cases are breaking down, or reactivating so as to require re-treatment, whereas the even greater reduction in the average daily census is a reflection of the fact that patients are being discharged from hospital more quickly, to continue treatment at home, but also to resume a normal life much more quickly than in former days. In 1972 our average stay was 99 days -- but this is an average for all patients discharged, and because patients admitted for investigation and assessment only stayed for a much shorter period, the hospital stay for patients with active moderately advanced and far advanced disease was obviously much higher.

It has been gratifying to note that during this same period there has been a gradual drop in the death rate for tuberculosis within the province, from 208 in 1908, to 62.6 in 1946 and 29.3 in 1949, to 2.2 in 1971. The figures for 1972 may as yet be incomplete, but with only 8 deaths reported for a population of 795,000, the death rate appears to be only 1.0 per 100,000 population. In Point Edward Hospital during 1972 we had three deaths, but these were due to non-tuberculous conditions -- two were cardiac, one due to cancer of the lung.

METHODS OF TREATMENT: Over the years the necessity for bed rest in the treatment of pulmonary tuberculosis has gradually been de-emphasized, while the importance of un-interrupted long-term combined chemotherapy is increasingly recognized. Whereas 25 yrs ago Streptomycin was reserved for only the more serious cases, and a six-week course of SM and PAS was considered adequate, today we treat the average case with combined therapy for two full years after the last demonstrated positive culture, so that total treatment period may be 27 to 30 months, and in some cases much longer, with life-long chest clinic follow-up thereafter.

Not only has the length of chemotherapy increased, but the variety of agents available has increased. Agents now in use at PEH include the original big three (Streptomycin, Isoniazid or INH, and PAS), with a number

of second-line drugs (Cycloseri· , Ethionamide, Pyrazinamide, and more rarely, Thiacetazone and Viomycin). Two very important new agents, Rifampin and Ethambutol, are now in use, and results have been encouraging.

The problems of allergy and toxicity remain, so that medication requires close supervision. Drug resistance has been a rare phenomenon -- at least it has rarely been reported to us by the DPH Laboratory, although we have cases where sputum conversion takes six to eight months instead of the usual three or less. But the problem cases of yesteryear, where the occasional patient would remain "positive" year after year, while each new antibiotic was added to his regimen as it became available, are no longer seen, and this improvement is due in part to the greater range of therapeutic agents now available, as well as to a better understanding of their use.

Resectional surgery still plays an important role, but in a decreasing number of patients. The surgical removal of areas of lung containing large caseous foci or unhealed cavities may improve both the immediate and the long-term prognosis. During 1972 twelve patients were transferred to the N.S. SAN, 7 of these for therapeutic resection, 1 for lung biopsy, 1 for surgery to a bone lesion, 2 for consultation only, and 1 to continue medical treatment.

FIRES IN OTHER INSTITUTIONS: Three times during its history the excess capacity of Point Edward Hospital has been utilized to assist other institutions damaged by fire:

(a) In February 1955 a fire in the elevator shaft of the Glace Bay General Tb Annex occasioned the emergency transfer of their patients to Point Edward Hospital, which was already considered to be "full". However, with the setting up of extra beds in the library, sunporches, etc., patients were cared for for a couple of weeks until they could return to their Unit.

(b) On May 8, 1970, one floor of the Cape Breton Hospital in nearby Sydney River was gutted by fire, and 99 patients were transferred, on an emergency basis, to two empty wards at Point Edward Hospital, and remained here for four days, until other arrangements were made for their return to the Cape Breton Hospital. These patients were not "admitted" to P.E.H.

(c) In the early morning hours of March 31, 1972 one wing of the Braemore Home, a municipal home for the disabled, at Sydney River, was destroyed by fire. Two patients lost their lives, returning into the burning building

after they had been removed, while 123 were safely evacuated to the Cape Breton Hospital next door. But because their facilities were badly overtaxed, on April 7th 69 Braemore patients were transferred to Point Edward Hospital, and lodged in Wards B and D. Subsequently we evacuated our "domestic staff residence", consolidating residence facilities for all our living-in staff in the nurses' residence. This enabled us to convert the West Wing of Ward D for dining-room and common-room space for Braemore, while looking after 117 of their patients, 51 in the hospital building and 66 in the residence. These 117 patients were not admitted to P.E.H., for the medical, nursing, and housekeeping care of the disabled remained the responsibility of the Braemore staff. But of course there were problems, the greatest of which fell on our dietary staff, who were immediately faced with a more than trippled dietary load. In building maintenance also there were problems, chiefly of water supply, where corroding water lines had over the years gradually reduced water pressure. Some lines had been replaced but in other areas the decreased patient load and the closing of unused wards had enabled us to get by with facilities which suddenly became inadequate to meet the now greatly increased requirements. Mandatory repairs were made, financed in places by the M.S. Department of Public Works and in places by the C.B. Jointex Board. Other problems of learning to work together and live together, while maintaining a segregation of the Tbc and the Braemore patients, were gradually resolved, with goodwill and cooperation on both sides.

FIRE HAZARD: In one respect, however, our hospitality to Braemore in their hour of need has had an unfortunate effect. Although following a July 17, 1972 inspection of the hospital by the Canadian Council on Hospital Accreditation, the hospital retained its Accredited Status for a further two year period -- PEH has been "accredited" continuously since 1954 -- nevertheless the Council noted with regret

> "that the entire character of the institution has changed through the occupation of the same physical plant by the guests from Braemore Home. The character of the institution has changed considerably, and thus the tolerance which has been shown in the past for the continuance of fire hazardous situation as far as the building is concerned cannot be extended indefinitely."

Reports from the Dominion Fire Commissioner and from the Provincial Fire

Marshall following detailed inspections of the premises made the same point, that the hospital buildings, built in 1942-43 with the combustible materials then available to meet temporary war-time needs, had out-lived their usefulness, that they would not meet present building code requirements, and that even with large expenditures to install fire-breaks and a sprinkler system, to renew electrical wiring and to make numerous lesser structural repairs and alterations, we would still be left with an old building which would not meet present fire protection regulations.

We had considered these hazards acceptable when we had a small number of patients of whom 90% were fully ambulant, and where even a small night-time staff should have no trouble evacuating the 10% of patients who might require assistance -- in fire drills the evacuation time for the building was approximately three minutes. However, the addition of 100-odd Braemore patients, most of whom were mentally defective, not only increased the direct hazard of fire but also increased the hazard that injury or death might result from a fire. When these facts were faced, there appeared to be no alternative to the decision that the building should be closed and patients moved to more suitable premises as soon as such could be found. Pending the actual move, we increased our "night-watchman" Commissionaire coverage from 10 hrs to 16 hrs, and Braemore also took on Commissionaires for 24 hrs over the weekends and 16 hrs on week nights.

OTHER PRESSURES TOWARDS CLOSURE:

The 1970 Annual Report of Point Edward Hospital was concluded with the comment:

"It is obvious that there has been a gradual decline in the number of Tbc patients admitted to Hospital, and in their length of stay, and it is likewise obvious that this is a continent-wide and even a world-wide phenomenon, a trend which is likely to continue. Declining utilization of hospital beds results in higher per-diem costs, and this increasing cost must of necessity put pressure on government to terminate an increasingly costly service and to spend the money elsewhere. Even if this were not so, the fact that the buildings were originally "temporary" and will not last forever, should require that plans be made for the future. With definite plans made, and a schedule and dates set, it should be possible to make intelligent plans for the patients, for the staff, and for the buildings and equipment.....

"A reasonable alternative should include a good chest unit in one of the general hospitals in the area, preferably in Sydney. It should have perhaps thirty beds for the admission, investigation, isolation and treatment of cases of pulmonary disease, including those of active infectious pulmonary tuberculosis.....

"Whatever changes the future may bring, an intensive anti-tuberculosis program must be maintained, stressing the early discovery of new active cases, adequate chemotherapy initiated in hospital but continued on a long-term properly supervised home therapy regimen (with uncooperative patients or those whose disease presents complications being readmitted to hospital for surgery or other necessary treatment), and stressing also a diligent searching out of contacts and life-long surveillance of all cases of once-active disease. With such a program Tuberculosis can be controlled, and we trust some day eradicated."

As far back as 1965 the Cape Breton Medical Society addressed itself to the problem of planning the improvement of health care delivery systems on the Island, and in 1971 a major study of the CAPE BRETON REGIONAL HEALTH SERVICES was funded by a federal health grant and undertaken by the Medical Society, employing Kates, Peat, Marwick & Company, and relying heavily on broad community cooperation in the study, with in-put from individuals, groups and organizations, and from the Medical Society. Their 3-volume report was published in the spring of 1972. The problem of Chest Disease was dealt with in Section XX-32:

"This high incidence of chest disease on the Island requires a pulmonary unit fully equipped to handle 40 patients. This unit will treat all chest complaints, including tuberculosis, silicosis and pneumoconiosis. Since Point Edward Hospital will ultimately be discontinued, provisions in this unit for infectious cases will be required.

"It has been suggested by several groups that the pulmonary unit could be established in one of the communities outside Sydney. The advantages of close association with the Regional Center suggest Sydney as the appropriate site. The presence of specialized diagnostic and therapeutic support services bolster this decision. For example, the pulmonary laboratory provides a highly specialized service available as a referred service both for in-patients and out-patients. Other services which are closely related are pulmonary radiology and thoracic surgery.

"This service in Sydney does not preclude inhalation therapy services from the community centers where justified.

"A close watch should be kept on the utilization rates of these beds, as changes in life styles, working environment and continued progress in chemotherapy should decrease the incidence of pulmonary diseases over the next few years."

In the fall of 1971, the report of the Federal-Provincial Study Team, the REPORT ON AN INTEGRATED SYSTEM OF HOSPITAL FACILITIES AND RELATED SERVICES, NOVA SCOTIA, was presented. It recommended:

138 That Point Edward Hospital should be closed at the earliest possible date.

139 This closure should be expedited by the temporary transfer of all tuberculosis patients to the Nova Scotia Sanatorium (and also, in # 82, that the N.S. Sanatorium be closed)

140 A 30 bed Chest Disease Unit should be established at the Cape Breton Regional Hospital.

And in the fall of 1972, a report on TUBERCULOSIS SERVICES, PRESENT AND FUTURE - NOVA SCOTIA, 1972, edited by Dr F. Russell Manuel and Dr. Peter C. Gordon, was presented to the Nova Scotia Council of Health.

Among its recommendations were:

1. That the emphasis in tuberculosis treatment be changed from inpatient to outpatient treatment.
2. That only 40 to 50 acute treatment beds will be required for the treatment of tuberculosis when adequate methods of non-hospital treatment are developed.
3. That in the immediate future all tuberculosis patients requiring inpatient treatment should be treated in general hospitals located at the following locations: Halifax, Kentville and Sydney. Other tuberculosis treatment centres might be developed after experience is gained in these three centres.
4. That tuberculosis specialists carry out the diagnostic evaluation and initiate the treatment and follow-up of all tuberculous patients.

Finally, the Report of the Nova Scotia Council of Health is currently in preparation, and is expected to deal with this matter also.

A CRYSTAL BALL? The decision to close out the present hospital building has been made. The necessity of retaining a continuing anti-tuberculosis program in Cape Breton has been recognized. The field of possible alternative sites is being narrowed, and the probability is that in March Point Edward Hospital will move to the Little Flower Building in Sydney, 115 Alexandra Street, not far from St. Rita Hospital, and that we will be sharing this building with the N.S. Commission on Drug Dependency, who will be operating an Alcohol and Drug Dependency Program, but that PEH will have 20-25 beds on the 2nd floor and facilities for a chest clinic on the first floor. With a smaller number of beds, patients will be discharged more quickly, to continue anti-Tb chemotherapy at home on a long-term basis. This will require a more intensive and sustained out-patient follow-up, to assure that effective treatment is continued on a long term basis. Failure of supervision will inevitably result in an increased incidence of treatment failures, and the spread of infectious disease to yet another generation of patients.

But Little Flower offers only a temporary solution. On the long-term

period there is an obvious need for a good Respiratory Center to be integrated with the Regional Hospital (St. Rita's ?), to handle not only the acute and follow-up investigation and treatment of tuberculosis, but also of the many other pulmonary problems of the area -- coal miners' pneumoconiosis, chronic bronchitis and emphysema, and the like. We would urge that steps be taken immediately to turn this dream of a Cape Breton Respiratory Center into a reality.

The need for an effective Alcohol and Drug Dependency program is great, and the probability is that this expanding program will require the whole of the Little Flower Building before the construction of a new Respiratory Center is completed. What then? The treatment of pulmonary tuberculosis in selected general hospitals is being undertaken elsewhere, and may be introduced here, although many of us long used to the careful isolation of tuberculosis in its acute infectious stage are fearful of a too casual approach, remembering that in a population becoming increasingly tuberculin-negative there is a greater danger of epidemic tuberculosis. But authorities agree that cases under effective anti-tuberculosis therapy rapidly become non-infectious, and that effective treatment long continued becomes the key to our continuing victory over this once dread disease.

BUT WHAT OF THE STAFF ?

When your present medical superintendent was transferred from Roseway Hospital to Point Edward in July 1961, he found a staff of 199 (130 Civil Servants and 61 Non-CS unionized domestic staff) plus a dozen student nurses. The students are no longer with us, as the six training schools who used to send us students for an Affiliate Course in Tuberculosis nursing dropped this when they introduced the 2-year course. Our full-time staff has been whittled down, largely by attrition, by failing to replace the greater number of those who resigned or retired, so that at present we have 73 Civil Servants, 20 non-CS unionized employees, and 1 "Casual". But while the staff has been cut in half, the patient body has been cut to one-fifth or one-sixth. Although the 100 or so Braemore patients add appreciably to our PEH staff chores, nevertheless it must be admitted that our staff-patient ratio is out of line. In the new smaller quarters at the Little Flower Building, without the Braemore patients to feed, albeit with some additional housekeeping and

dietary responsibilities to the Alcohol and Drug Dependency Clinic, some staff reductions will be necessary, and the process will inevitably be painful, the more so because so many of our employees have been with us for years, and have again and again demonstrated their loyalty and their capability. We have a good staff, and I am proud of them. Needless to say, every effort will be made to retain as many as possible and to find alternative employment for the others, but inevitably there will be many problems, and many heartaches. Is this the price of progress? It has always been said that our objective in the Tuberculosis Treatment Services has been to work ourselves out of a job! But so soon ?

AND WHAT OF THE PATIENTS? Patients also are concerned about the pending move. The numbers of patients may be falling through the years, but the need for active treatment persists. During 1972 41% of our tuberculous admissions had moderately advanced disease and 26% had far advanced disease, and most of these had positive sputum. Statistical details may be found in the appended tables. Facilities for looking after patients in the early stages of their treatment, while the disease is most highly infectious and while the chances of allergic or toxic reactions to medication is greatest, will be retained, but patients may look forward to a shorter stay in hospital, with a greater proportion of their total treatment course given at home. We trust that there will be a closer supervision of home therapy, so that it will be necessary to readmit to hospital only the occasional uncooperative patient or the rare patient developing complications requiring treatment either in Point Edward Hospital (Little Flower) or transferred to the N.S. Sanatorium.

TUBERCULOSIS TREATMENT IS A COOPERATIVE EFFORT The degree of success which the Province has achieved in its Tuberculosis Control Program has depended upon the cooperation of many individuals, and this spirit of working together for the common good must be retained. Success will depend on the patient, the family doctor, the staff of the general hospitals, the Public Health Nurse and other members of the Public Health Team, the many members of the Tb Hospital staff working together, with assistance from social service workers, the clergy, the patient's family and friends, the

community at large, and finally, the tax-payer. Thus to the many members of our health team, and particularly to our own hospital staff members, and to all our friends in the community who have supported us in so many ways, we express our deep appreciation for their cooperation and cheerful support in working towards our common goal.

D.S. Robb, M.D.
Medical Superintendent

P.S. Statistical tables follow, 1971 on buff paper, and 1972 on white.

The Twenty-Third

ANNUAL REPORT

of

POINT EDWARD HOSPITAL
N.S. Department of Public Health

Sydney, Nova Scotia

1971

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POINT EDWARD HOSPITAL

ANNUAL REPORT

For the Calendar Year ending December 31, 1971

TABLE 1 -- STATISTICAL REPORT OF ADMISSIONS AND DISCHARGES

	Male	Female	Total
Patients in hospital at beginning of year	24	17	41
Total Admissions during the year	101	45	146
Total Under Care during the year	125	62	187
Total Discharges during the year	100	53	153
Patients in hospital at end of the year	25	9	34
Total Patient-Days	9712	5351	15063
Average Daily Census			41
Patient-days of patients discharged or dead			20802
Average length of Hospital Stay			136

STATISTICAL REPORT -- COMPARISON WITH 5 RECENT YEARS

	1966	1967	1968	1969	1970
Patients in hospital at beginning of year	74	70	52	64	37
Total Admissions during the year	188	173	193	165	143
Total Under care during the year	262	243	245	229	180
Total Discharges during the year	192	191	181	192	139
Patients in hospital at end of the year	70	52	64	37	41
Total Patient-Days	29146	25129	21715	22263	14439
Average Daily Census	80	69	59	61	40
Patient-days of patients discharged or dead	35393	25217	20391	26391	22838
Average length of Hospital Stay	184	131	112	138	164

TABLE 2 -- ADMISSIONS DURING THE YEAR -- SOURCE OF PATIENTS

TUBERCULOUS	Male	Female	Total
First Admissions	34	14	48
Readmissions, to resume treatment	22	5	27
Readmissions, to continue treatment	5	1	6
Transfers from other Tb Hospitals	-	2	2
For review and Assessment only	17	11	28
Total	78	33	111
NON-TUBERCULOUS			
Staff	-	1	1
Other, for investigation and treatment	23	11	34
Total	23	12	35
Total Admissions	101	45	146

TABLE 3 -- ADMISSIONS: DIAGNOSIS OF PATIENTS ADMITTED -- 1971

TUBERCULOUS	Male	Female	Total	Percent
Primary	4	3	7	6.3
Minimal	14	10	24	21.7
Moderately advanced	31	11	42	37.8
Far advanced	20	7	27	24.3
Miliary	1	-	1	.9
Anthraco-silico-Tb	5	-	5	4.5
Osteitis, tbc	1	-	1	.9
Genito-urinary Tb	2	2	4	3.6
Total	78	33	111	100.0

NON-TUBERCULOUS	Male	Female	Total
Staff	-	1	1
Other, for investigation and treatment			
Anthraco-silicosis	1	-	1
Asthma, bronchial		2	2
Bronchitis, chronic	8	2	10
Bronchopneumonia	2	2	4
Bronchiectasis	2	1	3
Chronic bronchitis with chronic obstructive pulmonary emphysema	4	-	4
Chronic obstructive pneumonitis	-	1	1
Empyema, pyogenic	1	-	1
Fibrothorax	1	-	1
Haemoptysis	-	1	1
Ca of lung with metastasis	1	-	1
Ca of esophagus with mediastinal metastasis	1	-	1
Metastatic ca-lungs and liver	1	-	1
Metastatic ca-lymph glands	1	-	1
Osteochondritis juvenilis lumborum	-	1	1
Sarcoidosis	-	1	1
Tuberculous	78	33	111
Non-tuberculous - Staff	-	1	1
- Other	23	11	34
TOTAL ADMISSIONS	101	45	146

TABLE 4 -- ADMISSIONS: AGE and SEX of PATIENTS ADMITTED --1971

	TUBERCULOUS			NON-TUBERCULOUS			TOTAL		
Age	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-9	1	2	3	1	-	1	2	2	4
10-19	6	2	8	-	3	3	6	5	11
20-29	7	1	8	3	2	5	10	3	13
30-39	11	1	12	3	1	4	14	2	16
40-49	11	7	18	2	2	4	13	9	22
50-59	23	9	32	3	3	6	26	12	38
60-69	12	9	21	5	-	5	17	9	26
70-over	7	2	9	6	1	7	13	3	16
Total	78	33	111	23	12	35	101	45	146

TABLE 5 -- RESIDENCE OF PATIENTS ADMITTED:

Cape Breton County	109	
Inverness County	18	
Victoria County	11	
Richmond County	5	
CAPE BRETON ISLAND		143
Cumberland County	1	
Digby County	1	
Halifax County	1	
NOVA SCOTIA MAINLAND		3
TOTAL ADMISSIONS		146

TABLE 6 -- SPONSORSHIP OF HOSPITALIZED PATIENTS

	In Hosp Jan 1/71	Admitted 1971	Discharged 1971	In Hosp Dec 31/71	Hosp Days
Dept National Health & Welfare Indian and Northern -- Eskasoni Agency	1	19	18	2	1467
Dept of Veterans' Affairs	-	2	2	-	202
Total Federal Responsibility	1	21	20	2	1669
Province of Nova Scotia "	39	125	132	32	13376
Other Provinces - Reciprocity	1	-	1	-	18
TOTAL	41	146	153	34	15063

TABLE 7 -- DISCHARGES DURING THE YEAR: CLASS OF PATIENT -- 1971

	Male	Female	Total
Tuberculous	76	40	116
Non-tuberculous			
Staff	-	1	1
Other	24	12	36
Total	100	53	153

TABLE 8 -- DISCHARGES: ADMISSION DIAGNOSIS OF DISCHARGED TBC PATIENTS

	Male	Female	Total	Percent
Primary	3	2	5	4.3
Minimal	19	11	30	25.9
Moderately advanced	27	17	44	37.9
Far advanced	17	7	24	20.7
Miliary	1	2	3	2.6
Genito-urinary Tb.	2	1	3	2.6
Anthraco-silico-tuberculosis	6	-	6	5.2
Meningitis, tuberculous	1	-	1	.8
Total	76	40	116	100.0

TABLE 9 -- DISCHARGES: CLINICAL CONDITION OF PATIENTS ON DISCHARGE

	Male	Female	Total	Percent
Pulmonary Tuberculosis:				
Inactive	28	14	42	36.2
Quiescent	20	17	37	31.8
Active - improved	11	3	14	12.1
Active - unimproved	7	2	9	7.8
Dead - from Tb. or complication	1	-	1	.8
Dead - from unrelated disease	5	1	6	5.2
Extra-pulmonary Tuberculosis:				
Inactive	2	2	4	3.4
Quiescent	2	1	3	2.6
Total	76	40	116	100.0
Non-Tuberculous:				
Recovered or Improved	11	7	18	48.6
Unimproved (investigation only)	12	5	17	5.4
Dead	1	1	2	46.0
Total	24	13	37	100.0

TABLE 10 -- DISCHARGES: TYPE OF DISCHARGE OF TBC PATIENTS -- 1971

	Male	Female	Total	Percent
On Medical Advice	55	36	91	78.4
Transfer to N.S. Sanatorium	8	2	10	8.6
Irregular Discharges				
Against Advice	7	1	8	7.0
Died	6	1	7	6.0
Total	76	40	116	100.0

TABLE 11 -- MARITAL STATUS - ALL DISCHARGED PATIENTS

Single	38	12	50	32.7
Married	50	28	78	51.0
Widowed	8	7	15	9.8
Separated	4	6	10	6.5
Total	100	53	153	100.0

TABLE 12 -- RELIGION - ALL DISCHARGED PATIENTS

Roman Catholic	67	40	107	70.0
United Church of Canada	19	9	28	18.3
Church of England	8	3	11	7.2
Presbyterian	3	1	4	2.6
Pentecostal	1	-	1	.6
Protestant (Non-denominational)	2	-	2	1.3
Total	100	53	153	100.0

TABLE 13 -- PATIENTS DISCHARGED - TUBERCULOSTATIC DRUGS USED WHILE IN HOSP.

Streptomycin	72
Isoniazid	81
PAS	61
Cycloserine	26
Ethionamide	13
Ethambutol	9
Pyrazinamide	8
Isoxyl	1
Thiacetazone	3

TABLE 14 -- TBC PATIENTS DISCHARGED - ASSOCIATED TBC COMPLICATIONS
(for principal Tb Diagnosis refer to Table 8)

Bronchiectasis	12	Pleurisy with effusion, inactive	1
Bronchopleural fistula, inactive	2	Pneumonitis, tuberculous	1
Empyema, inactive	2	Peritonitis, inactive	1
Endobronchitis	1	Renal Tb	2
Pleurisy with effusion, active	4		

TABLE 15 -- TBC PATIENTS DISCHARGED - ASSOCIATED NON-TBC COMPLICATIONS -- 1971
(for principal Tb Diagnosis refer to Table 8)

Respiratory System:	
Bronchiectasis	2
Bronchopneumonia	5
Bronchitis, chronic	10
Chronic bronchitis with chronic obstructive pulmonary emphysema	1
Emphysema, compensatory	1
Emphysema, obstructive	3
Pulmonary Fibrosis	2
Radiation pneumonitis	1
Spontaneous pneumothorax	1
Diseases of the Skin:	
Cellulitis, pyogenic	1
Dermatitis, medicamentosa	1
Dermatitis, radiation	1
Dermatitis, varicose	1
Pilonidal sinus	1
Nervous System:	
Alcoholism	14
Anxiety state	6
Depressive reaction	2
Personality defect	1
Mental retardation	1
Schizophrenia	1
Epilepsy, idiopathic	1
Menopausal syndrome	3
Peripheral neuritis	1
Rubral Tremor	1
Gastrointestinal System:	
Duodenal ulcer	2
Hiatus hernia	1
Inguinal hernia	1
Cholelithiasis	2
Haemorrhoids	1
Genitourinary System:	
Benign prostatis hypertrophy	1
Chronic cystitis	2
Nephrosclerosis	1
Bones and Joints:	
Bursitis, pyogenic	1
Dupuytren's contracture	1
Fibromyostitis	1
Marie Strumpell's spondylitis	1
Osteomyelitis	1
Osteoarthritis	3
Periarticular fibrositis	1
Rheumatoid arthritis	1
E.E.N.T.:	
Chronic otitis media	1
Deafness, traumatic	1
Cardiovascular System:	
Arteriosclerotic cardiovascular disease	6
Atherosclerosis, obliterans	1
Atherosclerosis, generalized	1
Atherosclerosis, cerebral	1
Atherosclerosis, coronary	1
Cor Pulmonale	1
Hypertension, essential	2
Hypertensive cardiovascular disease	1
Hypertensive, atherosclerosis	1
Myocardial infarction	1
Toxic cardiomyopathy	1
Heart Block	1
Coronary thrombosis	1
Embolism, popliteal artery	1
Embolism, brachial artery	1
Varicose Veins	1
Systemic:	
Hypersensitivity to INH	1
Streptomycin toxicity	1
Cycloserine Toxicity	1
Lues	2
Hormonal System:	
Diabetes Mellitus	5

TABLE 16 -- REPORT OF OPERATING ROOM DEPARTMENT PROCEDURES -- 1971

BY OUR CONSULTANTS:	Major Surgery	Minor Surgery	Other Exams
E.E.N.T. PROCEDURES			
Bronchoscopics		9	
Oesophagoscopic		1	
E.E.N.T. Exams, consultations, etc.			5
UROLOGICAL PROCEDURES - Dr. D.B. Archibald			
Cystoscopic Exams		14	
Urethral Dilatations		12	
Other Examinations and consultations			3
BY OUR FULL-TIME MEDICAL STAFF			
Biopsy, Scalene Node		2	
Other		-	
Aspirations, chest		21	
other		4	
Lumbar Puncture		21	
Excision, warts, etc.		1	
Repair of Lacerations, etc.		5	
Plaster casts		3	
Exam - Proctoscopic, sigmoidoscopic			8
P.V.			2
Caloric Testing			4
NURSING PROCEDURES (by O.R. Staff)			
Dressings, etc.			153
Ear Syringe, etc.			11
Injections			7
Postural Drainage			23
E.C.G.			-
ANAESTHESIA			
General			0
Spinal			0
Local and Topical			89

TABLE 17 -- REPORT OF CLINIC SERVICES:

OUT-PATIENT CHEST CLINICS		Patients	Visits
D.V.A.	- Patients	104	
	- Visits		125
OTHER	- Patients	179	
	- Visits		327
STAFF CLINICS	- Patients	25	
	- Visits		177
	- Tuberculin Testing	14	

TABLE 13 -- LABORATORY REPORT: UNITS OF WORK PERFORMED -- 1971

	Total Exams	Unit Value	In-patient units	Out-patient units	Total Units
HAEMATOLOGY:					
Differential	876	2	994	7[illegible]	175[illegible]
Hematocrit	847	1	472	375	847
Haemoglobin	901	1	513	388	901
E. Sedimentation Rate	859	1	483	376	859
W.B.C.	[illegible]	1	498	380	878
			2960	2281	5241
URINALYSIS:					
Routine	561	2	1112	10	1122
Single constituents	9	1	8	1	9
			1120	11	1131
BIOCHEMISTRY:					
Bilirubin (direct + total)	7	4	24	4	28
Glucose	545	2	1042	48	1090
Glucose Tolerance	4	10	40	-	40
Icterus Index	293	1	210	83	293
Non-Protein Nitrogen	250	4	988	12	1000
Blood Urea Nitrogen	226	4	896	8	904
Alkaline Phosphatase	299	6	1278	516	1794
Protein, A/G ratio	18	6	108	-	108
SGOT	321	5	1170	435	1605
SGPT	320	5	1165	435	1600
Occult Blood	5	1	5	-	5
			[illegible]	1541	8467
TB BACTERIOLOGY:					
T.B. Direct Smear	128	3	384	-	384
T.B. Concentrated Smear	521	4	2084	-	2084
Other miscellaneous slides	3	2	6	-	6
			2474	-	2474
CEREBROSPINAL FLUID:					
Cell count	20	1	13	7	20
Chloride	20	3	39	21	60
Protein	20	2	26	14	40
Sugar	20	2	26	14	40
			104	56	160
COLLECTING UNITS			1391	[illegible]5	1986
TOTAL UNITS OF WORK PERFORMED			14975	4484	19459

(note: 284 units of Routine Staff health examinations, calibration and quality control, are included in the "outpatient units" above.)

TABLE 19: LABORATORY REPORT -- WORK REFERRED OUT TO OTHER LABORATORIES - 1971

	Total Exams	Unit Value	In-Patient Units	Out-Patient Units	Total Units
HAEMATOLOGY:					
Blood film	3	2	4	2	6
			4	2	6
BIOCHEMISTRY:					
Astrup	7	5	35	-	35
Calcium	29	4	116	-	116
Cephalin Cholesterol Floc	1	2	2	-	2
Chloride	29	3	87	-	87
Cholesterol	4	5	15	5	20
Phosphorus	29	4	116	-	116
Potassium	29	3	87	-	87
Sodium	29	3	87	-	87
Thyroxine	4	4	4	12	16
Uric Acid	4	3	-	12	12
			549	29	578
BACTERIOLOGY:					
T.B. Cultures	2767	6	16602	-	16602
Other cultures - sputum	170	6	1020	-	1020
- urine	82	6	492	-	492
- miscellaneous	60	6	330	30	360
Other sensitivities	142	4	560	8	568
Fungi culture	10	7	70	-	70
Ova concentration	2	4	8	-	8
			19082	38	19120
HISTOPATHOLOGY					
Surgical specimens	5	8	40	-	40
Cytology					
Sputum, bronchial washings	103	5	515	-	515
Cervical	2	4	8	-	8
			563	-	563
SEROLOGY:					
VDRL	144	1	143	1	144
Wassermann, etc	34	2	68	-	68
Paul-Bunnell	2	3	3	3	6
Cold Agglutinins	1	3	3	-	3
			217	4	221
URINALYSIS:					
Pregnancy	2	2	4	-	4
BLOOD BANK					
Cross match, etc	1	4	4	-	4
Group and Rh only	1	2	-	2	2
			8	2	10
TOTAL UNITS OF WORK REFERRED OUT:			20419	73	20492

TABLE 20 -- AUTOPSY STATISTICS -- 1971

Hospital deaths	9
(Deaths due to Tb - 1)	
Autopsies	4
Autopsy Rat	44%

TABLE 21 -- REPORT OF X-RAY DEPARTMENT -- 1971

	In-Patient Exams	Out-Patient Exams	Staff Exams	Total Exams	T.M. Units	R.M. Units
Chest, single	323	413	339	1031	2160	2160
" multiple	148	20	-	168	504	336
" planigraph	84	7	-	91	182	182
Bronchogram, unilateral	11	-	-	11	44	44
" bilateral	5	-	-	5	25	30
Abdomen, flat	-	-	-	-	-	-
" barium swallow	1	-	-	1	2	2
Gall Bladder	2	-	-	2	6	6
Pyelogram, I.V.	1	-	-	1	6	3
" retrograde	11	-	-	11	44	22
Bones and Joints:						
Ribs and shoulders	5	-	2	7	21	14
Skull, sinuses	3	1	-	4	12	12
Hips and pelvis	3	-	-	3	6	6
Spinal Column	17	3	1	21	84	84
Extremities	3	7	8	18	34	34
X-Ray examinations	617	456	350	1423	3132	2933
Electrocardiograms	33	1	-	34	136	
B.M.R.	1	-	-	1	4	
Pulmonary Function Tests	10	64	-	74	370	

The above films were interprated by our own medical staff. A few problem cases were referred to other radiologists, mostly to Dr. J.R. Corbett of St. Rita Hospital, and problem chest films were referred in consultation to the N.S. Sanatorium. Patients requiring G.I. Series and other specialist examinations were referred to the out-patient departments of nearby general hospitals.

Electrocardiograms were referred to Doctor H.H. Holden at the N.S. Sanatorium for interpretation.

Most patients admitted to Point Edward Hospital, or reporting to our P&I Out-patient Chest Clinics, had had previous chest x-rays elsewhere. Whever possible previous films were obtained and compared with our own films, as these comparative films taken over an interval of time gave a better picture of the stability or progression of a lesion than could a single examination. No exact count is kept of such previous films reviewed, but the figure would be in excess of 500 films or 1000 M.M. units.